C. Maximum Reimbursement for Covered Procedures and Materials for Ophthalmic Dispensers

(1) Reimbursement for covered services (a dispensing service fee or a repair fee) rendered by licensed ophthalmic dispensers to eligible recipients shall be the ophthalmic dispensers' usual and customary actual billed charges up to the fixed upper limit per procedure established by the department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS) on parity with medical doctors as described in item 2, below. Fixed upper limits not determined in accordance with the RBRVS methodology (due to factors such as availability) shall be set by the Cabinet using the following methodology.

The fixed upper limit for the procedure shall be consistent with the general array of rates for the type of service. "General array of fixed rates" means that the rate upper limit set for the procedure will be at the same relative level, so far as possible, as the rates for procedures which are similar in nature. The listing of similar services is referred to as the "general array". The actual upper limit is derived by using not less than 3 other sources such as Medicare, Workman's Compensation, other federal programs, other state or local governments, and health insurance organizations or if a rate is not available from these sources then we solicit rates from at least 3 of the highest volume instate providers of the services. After obtaining at least 3 rates, the rates are added together then divided by the number of rates to obtain an average rate which is then compared to similar procedures paid in comparable circumstances by the Medicaid program to set the upper limit.

(2) RBRVS units used shall be the same as those used in the physicians services program, with the units multiplied by the "all other services" conversion factor to arrive at the fixed upper limits for each procedure.

(3) Reimbursement for materials (eyeglasses or parts of eyeglasses) shall be made at the optical laboratory cost of the materials not to exceed upper limits for materials as set by the cabinet. An optical laboratory invoice, or proof of actual acquisition cost of materials, shall be maintained in the recipient's medical records for post-payment review. The agency upper limits for materials are set based on the agency's best estimate of reasonable and economical rates at which the materials are widely and consistently available, taking into consideration statewide billing practices, amounts paid by Medicaid programs in selected comparable states, and consultation with the optometric Technical Advisory Committee of the Medical Assistance Advisory Council as to the reasonableness of the proposed upper limits.

D. Reimbursement for other Supplies and Materials. Other supplies and materials such as cleaning fluid, cleaning cloth, carrying cases, etc., which are not eyeglasses or replacement/repair parts for eyeglasses, are considered to be provided in conjunction with and paid for as a part of the vision services rendered, and additional charges shall not be made to the cabinet or the recipient for these items.

E. Effect of Third Party liability. When payment for a covered service is due and payable from a third party source, such as private insurance, or some other third party with a legal obligation to pay, the amount payable by the cabinet shall be reduced by the amount of the third party payment.

F. Kentucky will comply with the requirements in Section 1905 of the Social Security Act relating to medically necessary services to EPSDT recipients. For services beyond the stated limitations or not covered under the Title XIX state plan, the state will determine the medical necessity for the EPSDT services on a case by case basis through prior authorization.

V. Hearing Services

A. The State Agency shall reimburse a participating audiologist at usual and customary actual billed charges up to the fixed upper limit per procedure established by the State Agency at sixty-five (65) percent of the median billed charge using 1989 calendar year billed charges. If there is no median available for a procedure, or the State Agency determines that available data relating to the median for a procedure is unreliable, the State Agency shall set a reasonable fixed upper limit for the procedure consistent with the general array of upper limits for the type of service. ("General array of fixed upper limits" means that the rate upper limit set for the procedure will be at the same relative level, so far as possible, as the upper limits for procedures which are similar in nature; the listing of similar services is what we referred to as a "general array.") Payment for a hearing aid furnished by the audiologist is reimbursed in the same manner as a hearing aid dealer.

Audiologists shall be entitled to the same dispensing fee or hearing aids as shown in Section B. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein.

B. Hearing Aid Dealers.

1. If the manufacturer of the hearing aid billed to the program has submitted a dealer price schedule which includes that hearing aid, the State Agency shall reimburse the participating hearing aid dealer at the lesser of:

a) That dealer price in the price schedule plus seventy-five (75) dollars for the first aid and twenty-five (25) dollars for the second aid when the two hearing aids are dispensed on the same date;

b) Actual dealer cost plus a professional fee of seventy-five (75) dollars for the first aid and twenty-five (25) dollars for the second aid when two hearing aids are dispensed on the same date; or

c) The suggested retail price submitted by the manufacturer for that aid.

2. If the manufacturer of the hearing aid billed to the program has not submitted a dealer price schedule which includes that hearing aid, the State Agency shall reimburse that participating hearing aid dealer at the lessers of:

a) The lowest dealer price submitted for a comparable hearing aid plus a professional fee of seventy-five (75) dollars or at the actual dealer cost plus a professional fee of seventy-five (75) dollars or twenty-five (25) dollars for the second aid when two hearing aids are dispensed on the same date;

b) The actual dealer cost plus a professional fee of seventy-five (75) dollars for the first aid and twenty-five (25) dollars for the second aid when two hearing aids are dispensed on the same date; or

c) The lowest suggested retail price submitted for a comparable aid. A comparable aid is defined as an aid falling within the general classification of fitting type, i.e., body, behind-the-ear, in-the-ear, eyeglasses.

c. Cords. The State Agency shall make payment for a replacement cord at the dealer's cost, plus professional fee set at the fixed ~~upper~~ limit

D. Hearing Aid Repairs. The State Agency shall reimburse a hearing aid dealer for a hearing aid repair on the basis of the manufacturer's charge for repair or replacement of parts, plus the dealer's cost for postage and insurance relative to the repair, plus a professional fee set at the fixed upper limit.

VI. Screening Services

A. The state agency shall reimburse individual providers for screening services in accordance with their usual payment procedures outlined in this state plan.

B. The state agency shall reimburse screening clinics or agencies on the basis of a pre-established fee which shall be related to the cost of service as follows:

(1) For a complete screening which includes all items or procedures appropriate to age and health history of the recipient, except the fifth year (kindergarten examination)and twelfth year (sixth grade examination), the fee shall be seventy (70) dollars per recipient screened;

(2) For a complete screening for the fifth and twelfth years, the fee shall be ninety (90) dollars per recipient screened;

(3) For a partial screening, which shall include at least a health history and unclothed physical examination, the fee shall be thirty (30) dollars per recipient screened;

(4) For completion of a partial screening with some items or procedures appropriate to age and health history of the recipient provided as a follow-up to a partial screening, the fee shall be forty (40) dollars per recipient screened.

(5) For an interperiodic screen, which shall be medically necessary to determine the existence of a suspected physical or mental illness and in addition to the regular periodicity scheduled screenings, the fee shall be thirty (30) dollars per recipient screened.

(6) In no instance may the fee paid in accordance with items (1) through (5) exceed the usual and customary fee of the provider for the service.

VI-A. Payments for Non-covered Services Provided Under the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

When services within the definition of medical services as shown in Section 1905(a) of the Act, but not covered in Kentucky's title XIX state plan, are provided as EPSDT services, the state agency shall pay for the services using the following methodologies:

(1) For services which would be covered under the state plan except for the existence of specified limits (for example, hospital inpatient services) the payment shall be computed in the same manner as for the same type of service which is covered so long as a rate or price for the element of service has been set (for example, a hospital per diem). These services, described as in Section 1905(a) of the Social Security Act, are as follows:

(a) 1905(a)(1), inpatient hospital services;
(b) 1905(a)(2)(A), outpatient hospital services; 1905(a)(2)(B), rural health clinic services; 1905(a)(2)(C), federally qualified health center services;
(c) 1905(a)(3), other laboratory and X-ray services;
(d) 1905(a)(4)(B), early and periodic screening, diagnosis, and treatment services; 1905(a)(4)(C), family planning services and supplies;
(e) 1905(a)(5)(A), physicians services; 1905(a)(5)(B), medical and surgical services furnished by a dentist;
(f) 1905(a)(6), medical care by other licensed practitioners;
(g) 1905(a)(7), home health care services;
(h) 1905(a)(9), clinic services;
(i) 1905(a)(10), dental services;
(j) 1905(a)(11), physical therapy and related services;
(k) 1905(a)(12), prescribed drugs, dentures, and prosthetic devices; and eyeglasses;
(l) 1905(a)(13), other diagnostic, screening, preventive and rehabilitative services;
(m) 1905(a)(15), services in an intermediate care facility for the mentally retarded;
(n) 1905(a)(16), inpatient psychiatric hospital services for individuals under age 21;
(o) 1905(a)(17), nurse-midwife services;
(p) 1905(a)(18), hospice care;
(q) 1905(a)(19), case management services; and
(r) 1905(a)(~~21~~ 22), other medical and remedial care specified by the Secretary. P&I HCFA 5-15-92

(2) For all other uncovered services as described in Section 1905(a) of the Social Security Act which may be provided to children under age 21 the state shall pay a percentage of usual and customary charges, or a negotiated fee, which is adequate to obtain the service. The percentage of charges or negotiated fee shall not exceed 100% of usual and customary charges, and if the item is covered under Medicare, the payment amount shall not exceed the amount that would be paid using the Medicare payment methodology and upper limits. Services subject to payment using this methodology are as follows:

(a) Any service described in 1, above, for which a rate or price has not been set for the individual item (for example, items of durable medical equipment for which a rate or price has not been set since the item is not covered under Medicaid);
(b) 1905(a)(8), private duty nursing services;
(c) 1905(a)(20), respiratory care services;
(d) 1905(a)(21), services provided by a certified pediatric nurse practitioner or certified family nurse practitioner (to the extent permitted under state law and not otherwise covered under 1905(a)(6); and
(e) 1905(a)(24), other medical or remedial care recognized by the Secretary but which are not covered in the plan including services of Christian Science nurses, care and services provided in Christian Science sanitoriums, and personal care services in a recipient's home.

VII. Transportation Services

A. Ambulance Services.

(1) The department shall reimburse licensed participating ambulance services at the lesser of their usual and customary charges or the maximum rate established by the department.

(2) The maximum rate shall be the amount arrived at by combining the base rate, mileage allowance, oxygen rate, and cost of other supplies, as applicable:

(a) The base rate for Advanced Life Support (ALS) emergency transportation to the emergency room of a hospital shall be set at eighty-five (85) dollars per one (1) way trip; the mileage allowance for trips shall be three (3) dollars and fifty (50) cents per mile for mileage from mile one (1); a flat rate of twenty-five (25) dollars shall be set for each additional recipient with no additional allowance for mileage.

(b) The rate for air ambulance transportation shall be an all-inclusive rate. Reimbursement shall be the provider's usual and customary charge not to exceed the upper limit of $3,500. All claims for air ambulance transportation services shall be submitted to the Department for Medicaid Services and shall be reviewed for determination that air transport was medically necessary and appropriate.

(c) The base rate for Basic Life Support (BLS) emergency transportation to the emergency room of a hospital shall be set at sixty-five (65) dollars per one (1) way trip; the mileage allowance for trips shall be two (2) dollars and fifty (50) cents per mile for mileage from mile one (1); a flat rate of twenty (20) dollars shall be set for each additional recipient with no additional allowance for mileage.

(d) The base rate for any ALS or BLS providing emergency ambulance transportation to an appropriate medical facility or provider which is not the emergency room of a hospital shall be set at fifty-five (55) dollars per one (1) way trip; the mileage allowance for trips shall be two (2) dollars per mile for mileage from mile one (1); a flat rate of fifteen (15) dollars shall be set for each additional recipient with no additional rate for mileage. Payment shall be contingent upon review of required documentation. Claims shall be reviewed by the Department for Medicaid Services. Required documentation shall be a statement of a medical emergency by the attending medical provider.

(e) The base rate for nonemergency health transportation (NEHT) services when transporting a recipient who is on a stretcher to a medical provider, other than a pharmacy, shall be set at forty (40) dollars per one (1) way trip; the mileage allowance for trips shall be one (1) dollar and fifty (50) cents per mile. The reimbursement for NEHT services when transporting a recipient who is in a wheelchair shall be as a specialty carrier.

(f) The base rate for nonemergency transportation for all licensed ambulance services when no medical care or treatment of a recipient is required or indicated during transport shall be the rate specified in item (e) of this section.

(g) An oxygen rate, will be set at ten (10) dollars per one (1) way trip; for all licensed ambulance services, excluding air ambulances.

(h) The cost of other itemized supplies for ALS or BLS emergency transportation services shall be the actual cost as reflected on the transportation provider's invoice which shall be maintained in the provider's files and shall be produced upon request by the department.

B. Commercial Transportation Carriers

The department shall reimburse participating commercial transportation carriers at usual commercial rates with limitations as follows:

(1) For taxi services provided in regulated areas the provider shall be reimbursed the normal passenger rate charged to the general public for a one (1) way trip regardless of the number of Medicaid eligible recipients transported when the trip is within the medical service area. The taxi shall be paid the single passenger rate regardless of the number of additional passengers.

(2) For taxi services in those areas of the state where taxi rates are not regulated by the appropriate local rate setting authority, and for taxi services in regulated areas when they go outside the medical service area, the provider shall be reimbursed the normal passenger rate charged the general public for a single passenger (without payment for additional passengers, if any) up to the upper limit; reimbursement for transport of a parent or attendant shall be considered included within the upper limit allowed for the trip. The upper limit for a taxi transporting a recipient shall be:

(a) The usual and customary charge up to a maximum of six (6) dollars for trips of five (5) miles or less, one (1) way, loaded miles.

(b) The usual and customary charge up to a maximum of twelve (12) dollars for trips of six (6) to ten (10) miles, one (1) way, loaded miles.

(c) The usual and customary charge up to a maximum of twenty (20) dollars for trips of eleven (11) to twenty-five (25) miles, one (1) way, loaded miles.

(d) The usual and customary charge up to a maximum of thirty (30) dollars for trips of twenty-six (26) miles to fifty (50) miles, one (1) way, loaded miles.

(e) For trips of fifty-one (51) miles or above shall be the lesser of the usual and customary charge or an amount derived by multiplying one (1) dollar by the actual number of miles, not to exceed a maximum of seventy-five (75) dollars per trip, one (1) way, loaded miles.

C. Private Automobile Carriers.

(1) The department shall reimburse private automobile carriers at the basic rate of twenty-two (22) cents per mile plus a flat fee of four (4) dollars per recipient if waiting time is required. For round trips of less than five (5) miles the rate shall be computed on the basis of a maximum allowable fee of six (6) dollars for the first recipient plus four (4) dollars each for waiting time for additional recipients. Private automobile carriers shall have a signed participation agreement with the Department for Medicaid Services prior to furnishing reimbursable medical transportation services.

(2) For round trips of five (5) to twenty-five (25) miles the rate for private automobile carriers shall be computed on the basis of maximum allowable fee of ten (10) dollars for the first recipient plus four (4) dollars each for waiting time for additional recipients. The maximum allowable fee rates shall not be utilized in situations where mileage is paid.